Chapter 7. The Safety Net's Role in Serving the Uninsured in Washington

Introduction

Approximately 484,000 Washington residents under age 65 were uninsured in 2000. Although these individuals do not have health insurance, they may continue to need and seek health care. Access to providers may be more limited for the uninsured, but these residents do have places to go for care. The system of health care for the uninsured is known as the *safety net*. The safety net exists to some degree in all communities of the state, but access to the safety net is a central issue for uninsured individuals who seek health care.

This chapter examines the safety net in Washington and access to the safety net, which includes the number of safety net institutions, the volume of care provided by safety net providers, and the physical location of the safety net institutions. We also examine gaps that exist in the safety net, highlighting the areas of the state that may have a shortage of designated safety net providers.

Safety net providers are those health care providers that care for a disproportionate number of people who do not have the resources to pay for health care. Most doctors and hospitals serve this population and, taken together, may provide the bulk of charity care in the state. Safety net providers, however, have explicit missions to address the needs of the uninsured.* Safety net providers include some (especially sole community) hospitals, community and migrant health centers, and rural health centers.

The demand for safety net services in Washington is expected to increase due to the economic recession and growing unemployment. In October 2001, the United States Labor Department reported that Washington had the highest unemployment rate in the country, at 6.6 percent, and in January 2002 it had the second highest unemployment rate at 7.5 percent.† High unemployment rates tend to be correlated with higher rates of uninsurance. In Washington, the rate of the uninsurance is highest for people with no employed family members (see Chapter 2, page 25). Designated safety net providers will most likely absorb much of the increased demand for care from uninsured and unemployed residents of the state.

*Institute of Medicine. (2000). *America's Health Care Safety Net: Intact but Endangered*. Washington D.C.: National Academy Press.
†*Seattle Times*, November 21, 2002 and February 19, 2002.

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Major Findings

Safety Net Capacity

The capacity of Washington's safety net to serve the uninsured population is strong, especially when compared to the safety net in other states. Washington ranks high among states in several research studies that sampled safety net resources. Long and Marquis* found that Washington, along with Florida and New York, ranked as one of the top 3 of 10 states in safety net capacity. Holahan and Spillman† found that Washington was in the top 4 of 13 states with the least vulnerable safety nets.

These studies differ in the implications of having a strong safety net. Long and Marquis reported that uninsured children visited health care providers with substantially higher frequency in states with a high safety net capacity. Holahan and Spillman found that no difference existed between the insured and the uninsured in the frequency with which they visited health care providers in states that had stronger and weaker safety nets.

This apparent variance is important for policy formulation. The Long and Marquis result suggests that expanding the safety net may be a way to increase access. The Holahan and Spillman finding suggests that expanding insurance, rather than expanding the safety net, may be a better way to improve access.

Delivery of Safety Net Care

- Relatively few hospitals provide most of the hospital charity care that is delivered in Washington. Nineteen of the 90 hospitals in the state provided 76 percent of all hospital charity care in 1999.
- Rural hospitals report less charity care as a percent of their total adjusted revenue than do urban hospitals. In 1999, rural hospitals contributed 1.5 percent of adjusted revenue (excluding Medicare and Medicaid) to charity care. Urban hospitals contributed 2.3 percent of adjusted revenue to charity care.
- The number of uninsured patients served by community and migrant health centers increased by more than 34 percent from 1992 to 2000. The uninsured dropped as a percentage of all patients seen by these community health centers from 39 percent to 29 percent during the same time period.

*Long, S.H. & Marquis, M.S. (1999). Geographic Variation in Physician Visits for Uninsured Children: The Role of the Safety Net. *Journal of American Medical Association*, 281 (21), 2035-2040.
†Holahan, J. & Spillman, B. (January 2002). Health Care Access for Uninsured Adults: A Strong Safety Net is Not the Same as Insurance. *New Federalism, Series B, No B-42*, The Urban Institute.

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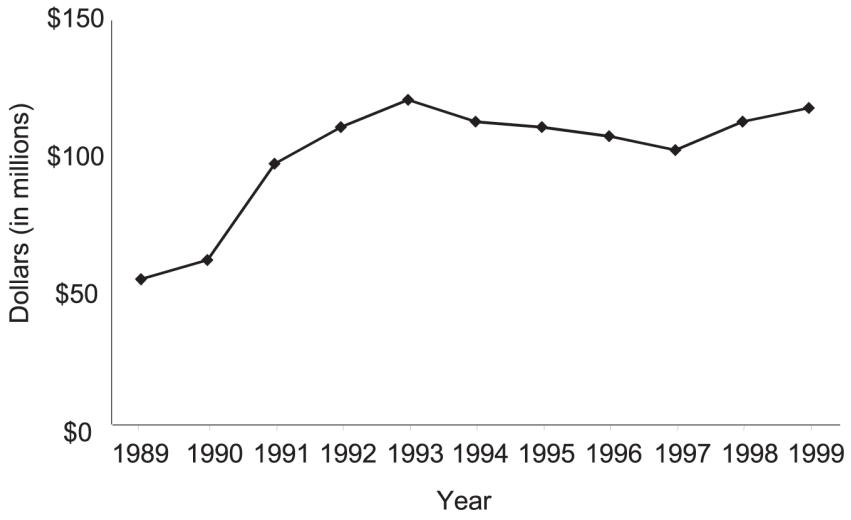
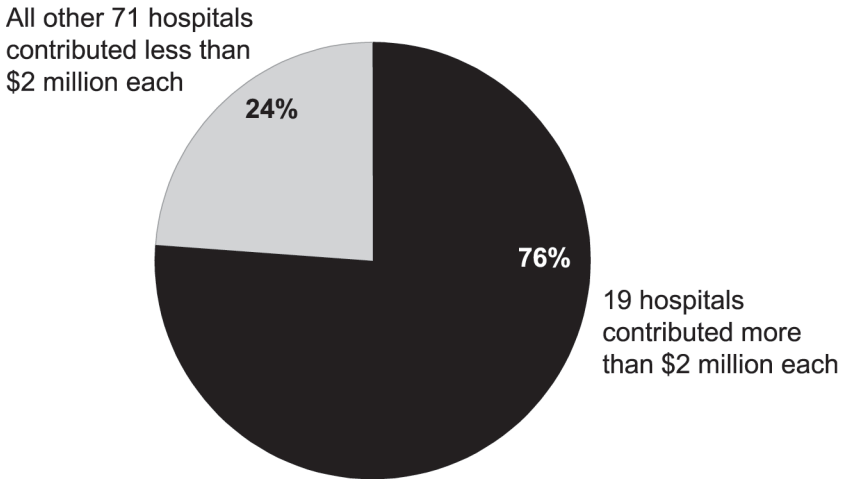
Figure 7-1. Hospital Charity Care Spending, 1989 to 1999



Source: Washington State Department of Health, Center for Health Statistics, 1999.

Figure 7-2. Total Hospital Charity Care Spending by Whether Hospital Contributes More or Less than $2 Million in Charity Care, 1999



Source: Washington State Department of Health, Center for Health Statistics, 1999.

Hospital Charity Care

Among all hospitals in Washington, spending for charity care increased during the 1990s. In 1989 hospitals contributed just over $50 million to charity care. By 1999 hospitals more than doubled the total amount. However, in the mid-1990s the amount of charity care stabilized and even declined slightly, perhaps due to expansion of Medicaid coverage for children and increased enrollment in Basic Health during this period.

The amount of charity care provided as a percent of adjusted revenue decreased by 1 percentage point from 1996 to 1999—from 3.2 percent to 2.2 percent. Adjusted revenue represents how much charity care is provided excluding Medicare and Medicaid revenues, which may give us a better sense of what hospitals contribute to charity care.

A majority of hospital charity care spending in Washington is accounted for by relatively few hospitals. Nineteen hospitals each provided more than $2 million of charity care in 1999. This amounted to 76 percent of all hospital charity care spending in the state. Harborview Medical Center alone provided more than 23 percent of total hospital charity care.

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Figure 7-3. Hospital Charity Care by Region

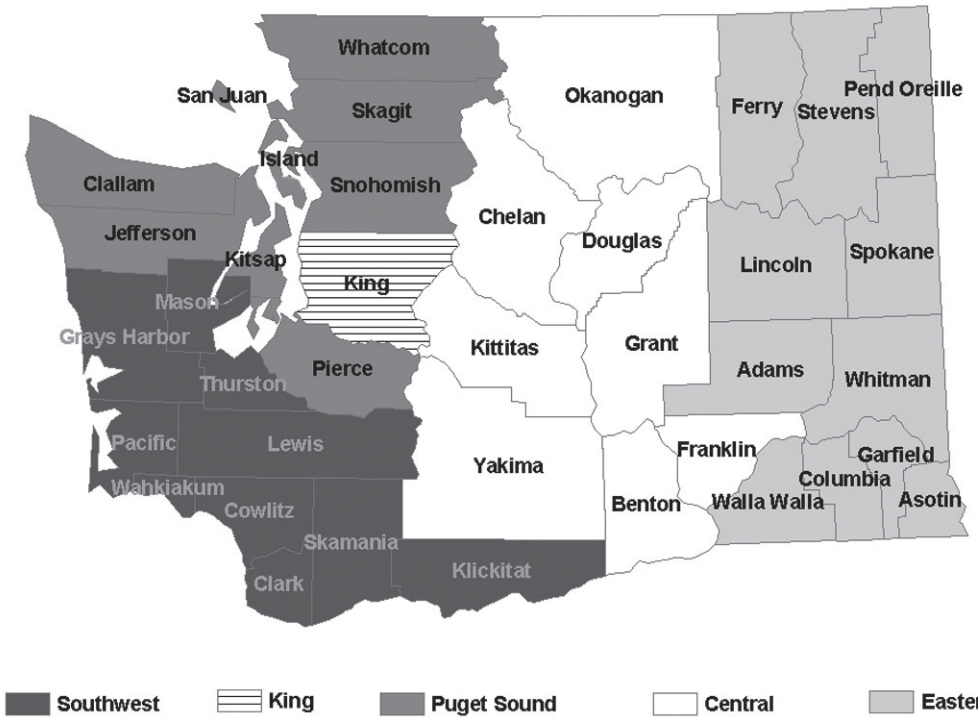
Hospital Charity Care by Region in Washington				
Charity Care as a Percent of Adjusted Revenue				
Hospital Region	**1996**	**1997**	**1998**	**1999**
King County	3.3	3.0	2.9	2.4
Central Washington	3.3	2.7	2.5	2.4
Southwest Washington	3.4	2.8	2.4	2.3
Puget Sound	2.8	2.2	1.8	1.8
Eastern Washington	3.3	2.2	2.2	1.8
Statewide	**3.2**	**2.6**	**2.5**	**2.2**

Source: Washington State Department of Health, Center for Health Statistics, 1999. Charity Care in Washington Hospitals.

From a regional perspective, hospitals in King County provide the greatest dollar amount of charity care. However, this picture changes considerably when Harborview Medical Center's $26.6 million is excluded. Then charity care in King County drops from 2.4 percent of adjusted revenue to 1.5 percent. Other King County hospitals provide charity care at levels comparable to rural hospitals.

Rural hospitals report less charity care, in proportion to their total adjusted revenue, than do urban hospitals. Overall, rural hospitals provided $8.8 million of charity care in 1999, amounting to 1.5 percent of adjusted revenue. Charity care for urban hospitals amounted to 2.3 percent of adjusted revenue.

Figure 7-4. Hospital Regions in Washington



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Community and Migrant Health Centers

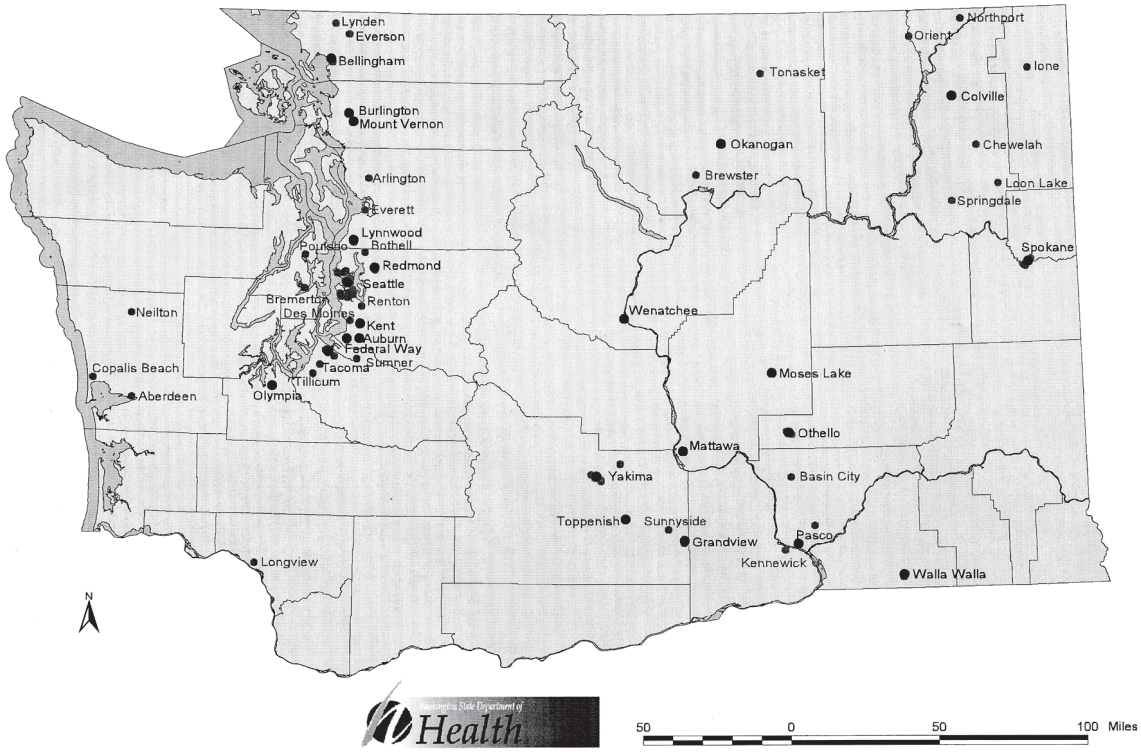
In 2000, the Washington Association of Community and Migrant Health Centers (WACMHC) reported that 21 community and migrant health centers operated 80 medical and 40 dental sites throughout the state as members of their organization. These community and migrant health centers provide comprehensive primary health care in both urban and rural areas. However, they tend to be located where the population clusters are largest, in the more urban areas. From the map below (Figure 7-5), we can see that the greatest concentration of community and migrant health centers is located along the I-5 corridor in the western part of the state.

Funding for Community Health Centers

Community health centers receive funding from multiple sources, the largest of which is payments by third-party payers such as Medicare, Medicaid, and private insurance. Another large source of income comes from grants received from federal, state, and local governmental agencies. These grants account for 26.7 percent of the total funding received by the clinics.

The Health Care Authority's Community Health Services grant program funds some of the community health centers in the state. In 2000, Community Health Services gave over $6 million to 29 not-for-profit community health centers with approximately 120 delivery sites throughout the state.*

Figure 7-5. Community and Migrant Health Centers and Dental Clinics, 2002



*Washington State Health Care Authority. (2001). Community Health Services 2000 Annual Report. Olympia, WA

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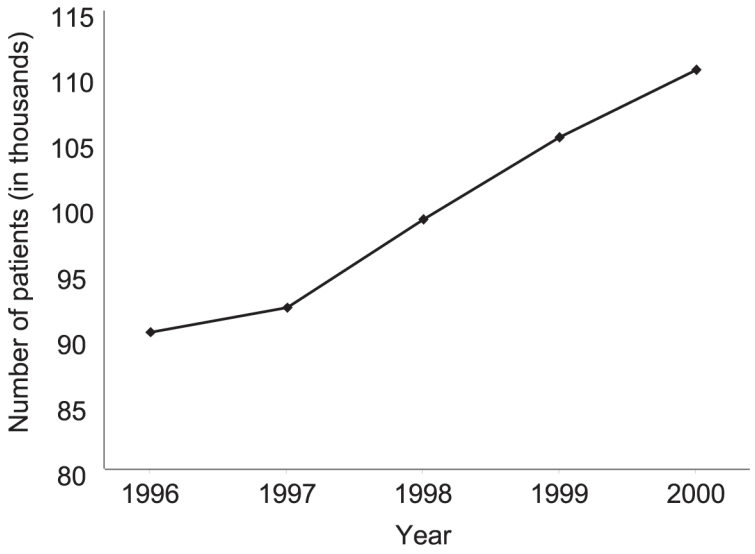
Figure 7-6. Uninsured Patients Served in Washington Community and Migrant Health Centers, 1996 to 2000

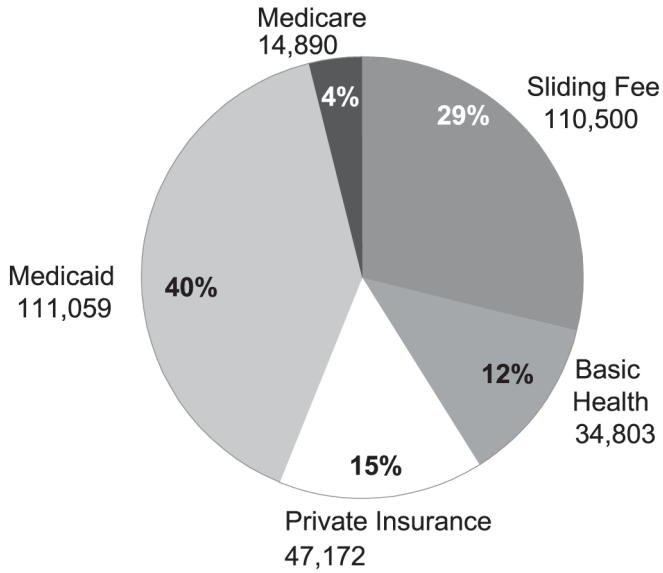


Source: Washington Association of Community and Migrant Health Centers, 2001.

Community and Migrant Health Center Charity Care

Among community and migrant health centers in Washington, the number of uninsured patients has increased by more than 34 percent since 1992, from 86,700 to 110,500 in 2000. However, uninsured patients as a percentage of all patients seen by these community health centers has decreased. In 1996, uninsured visits represented 39 percent of all patients; by 2000 this proportion had dropped to 29 percent of all patients.

Figure 7-7. Patients By Payment Source in Community and Migrant Health Centers, 2000



Source: Washington Association of Community and Migrant Health Centers, 2001.

The number of sliding-fee patients served by community and migrant health centers has increased by 15 percent since 1996, from 84,300 to 96,800 in 2000. As a payment source, sliding-fee clients, who are virtually all uninsured, represented 29 percent of all community and migrant health center patients in 2000. The only payment source that represents more of the patient base is Medicaid, at 40 percent.

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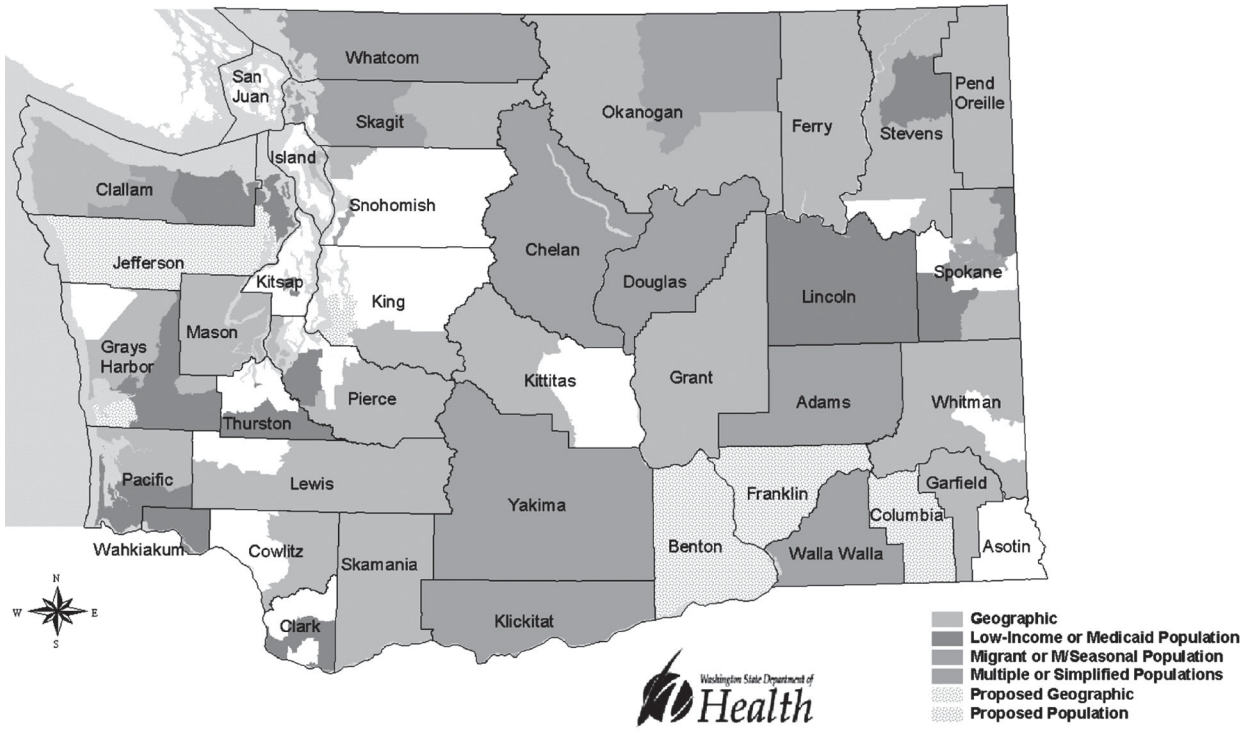
Health Professional Shortage Areas

The federal government designates areas of the state that have a shortage of primary care medical professionals and dental professionals as Health Professional Shortage Areas (HPSAs). HPSAs can be (1) An urban or rural area, (2) a population group, or (3) particular institutions that serve HPSA residents. In 1998, the Office of Community and Rural Health at the Washington State Department of Health estimated that federal shortage designations allowed local clinics, providers, and health jurisdictions to qualify for $35 to $50 million in federal funds through enhanced Medicare and Medicaid reimbursements.

HPSAs have become especially important since 1997 when the federal Balanced Budget Act allowed for the designation of private medical practices in Health Professional Shortage Areas as Rural Health Centers. The Office of Community and Rural Health has been very aggressive at getting HPSAs designated in Washington. As is evident from the map below (Figure 7-8), only a few areas of the state have not been designated as HPSAs; almost 90 percent of the state lies in a Health Professional Shortage Area.

Figure 7-8. Federally Designated Primary Health Care Shortage Areas in Washington, 2002



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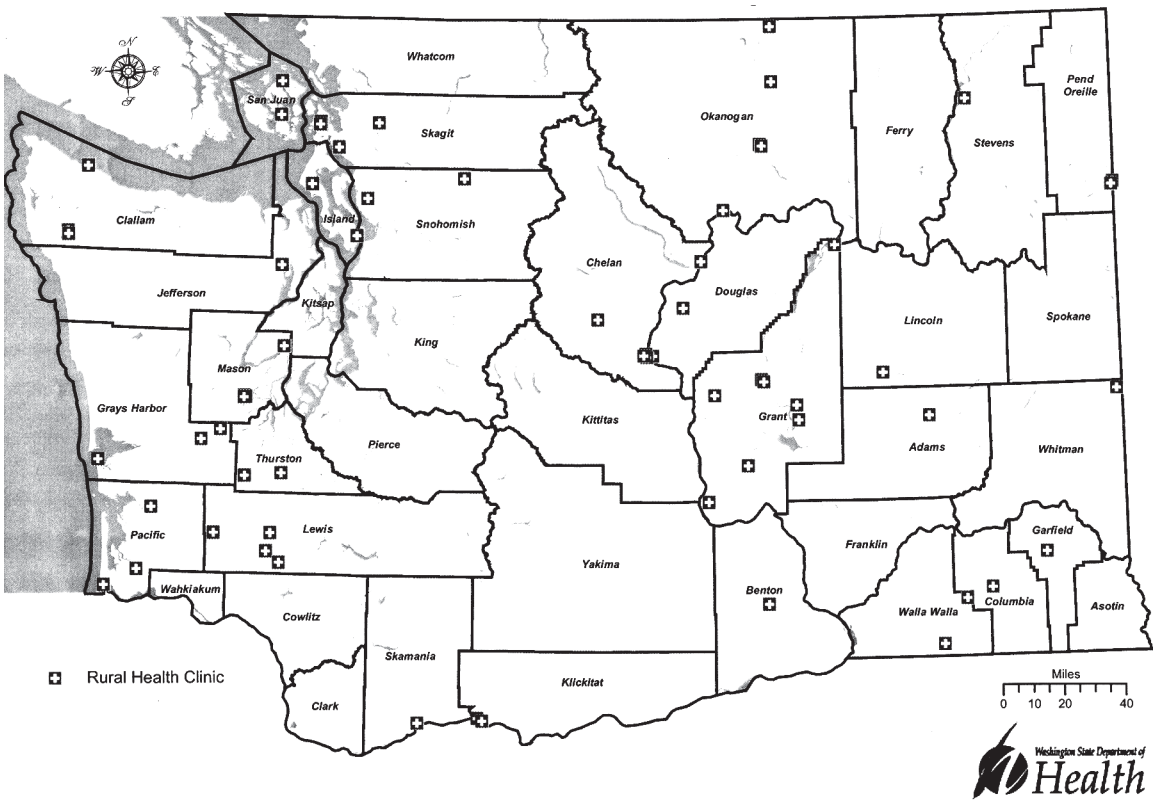
Rural Health Centers

The federal Centers for Medicare and Medicaid Services (CMS) designates clinics and private medical practices that provide primary care services to individuals in rural underserved areas as Rural Health Centers (RHCs). The designation means that the clinic or private practice will receive enhanced Medicare and Medicaid reimbursement. Initial eligibility requirements include: (1) location in an updated—within the past three years—Health Professional Shortage Area or Medically Underserved Area; and (2) location in a rural or non-urbanized area, according to the U.S. Census Bureau.

The volume of care provided by RHCs is unknown, because no centralized reporting structure exists. CMS does not require that RHCs see uninsured patients, offer a sliding-fee scale, or post the sliding-fee schedule even if one is offered. RHC status is becoming more and more important to clinics and doctors in rural areas. As Medicare payments have declined, many more providers have expressed interest in RHC designation. Washington has a total of 70 RHCs, and as many as 40 providers have expressed interest in certification by early 2002. From the map below (Figure 7-9), we can see that Rural Health Centers also tend to be focused along the I-5 corridor in the western part of the state.

Figure 7-9. Rural Health Centers in Washington, 2002



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